

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes () No
Requestor's Name and Address Texas Imaging & Diagnostic Ctr. 3840 W. NW. Hwy., Ste 400 Dallas TX 75220	MDR Tracking No.: M4-03-7511-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address BOX #: 17 Federal Ins. Co. / Chubb Ins. c/o Harris & Harris PO Box 162493 Austin TX 78716	Date of Injury:
	Employer's Name: Datatrac Info. Services
	Insurance Carrier's No.: 717082038

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6/5/02	6/5/02	76000-26	\$88.00	\$88.00
6/5/02	6/5/02	99499-RR	\$69.00	\$0.00

PART III: REQUESTOR'S POSITION SUMMARY

6/3/03: "In reference... The insurance company has denied payment for the Fluoroscopy...(F)...it is a separate code when used in ESI injections...I have attached the observation room record for your review. The patient was taken to the recovery and observation area for monitoring of any possible adverse effects from the injection procedure...necessary requirements and how we meet them, copies of our supply sheets describing charges and EOB's from various insurance companies that pay this code in full and in accordance with TWCC fee guidelines. I have also attached a copy of an EOB on the same patient, same procedure, same carrier and they allowed payment per the TWCC Guidelines..."

PART IV: RESPONDENT'S POSITION SUMMARY

7/16/03: "Enclosed herewith is...position taken by Respondent...The Carrier has denied reimbursement for this procedure as it was neither reasonable nor necessary for the management of the Claimant's compensable injury...The need for fluoroscopy in this particular instance in not clearly delineated..."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT code 97000-26 for DOS 6/5/02 was denied 'F-Fee guideline MAR reduction included in another billed procedure.' According to MFG/ Radiology/Nuclear Medicine Ground Rules (I) (A) (3) and CPT descriptor,
the requestor submitted convincing evidence to support services rendered. Reimbursement recommended per MAR in the amount of \$88.00.

CPT code 99499-RR for DOS 6/5/02 was denied 'M-No MAR, reduced to fair and reasonable. According to MFG/NMGR (I) (A) (3) and MFG/SGR (V)(B)(3), additional reimbursement can not be recommended.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$88.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Carol Lawrence

03/29/05

Authorized Signature

Typed Name

Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____